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Designing a trauma informed service to deliver trauma therapy with people experiencing homelessness: a qualitative study

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Abstract

Background People who are homeless experience an increased prevalence of traumatic events, including childhood trauma, trauma related to being homeless, and structural trauma. It is important to consider trauma in the delivery of health services for this population. Using a trauma-informed care approach is one way to ensure that a service or program takes into consideration the effects of trauma. The aims of this study are to describe how best to design a service to engage people experiencing homelessness in a trauma-focused therapy as well as detail what trauma-informed care would look like in this setting.

Methods We conducted a series of qualitative interviews about how to design a trauma-informed trauma therapy for people experiencing homelessness and their perspectives on different principles of trauma-informed care. Thematic analysis was used to identify, analyze and report themes identified in the data.

Results We conducted 12 in-depth interviews (8 women, 4 men) with people who were currently peer support workers with lived experience of trauma and homelessness. We identified themes to design a trauma-informed service including low-barrier access, communication strategies, meeting people's needs, and how to engage and retain people in the service. We also identified themes related to how people with lived experience understand the principles of trauma informed care.

Discussion The findings from this study provide insight and practical recommendations for designing and implementing a trauma-informed therapy tailored for people experiencing homelessness. The findings here shed light on the lived experience perspective of trauma-informed care principles, adding nuance to our understanding of what it means to be trauma-informed.

Keywords Trauma-informed care, People experiencing homelessness, PTSD, Complex PSTD, Service design

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Background

Adverse childhood experiences including abuse, neglect and household challenges are common in people experiencing homelessness. Nearly nine out of ten people experiencing homelessness report at least one adverse childhood event and half report four or more adverse childhood events, which is about ten times greater than the general population [1–3]. In addition to historical trauma, the experience of homelessness itself can be traumatic through the loss of stable housing, loss of supportive relationships, increased risk of violence such as physical or sexual assault, and the uncertainty of not meeting basic needs such as food and hygiene [4–7]. This can also be further compounded by trauma resulting from structural violence, such as racism, gender-based violence, and intergenerational trauma [8–12]. One consequence of these cumulative experiences is high rates of post-traumatic stress disorder (PTSD) and complex PTSD (cPTSD) in people experiencing homelessness, with rates of PTSD ranging between 21% and 53% [13–16] and rates of cPTSD possibly as high as 60% [17, 18]. Taking into consideration the impact of traumatic events when delivering care and services is a key factor in engagement and effectiveness.

Trauma-informed care is a framework for providing services to individuals who have experienced a traumatic event. It was originally developed as an organizational response to high rates of trauma in people accessing mental health services. To be trauma-informed is to understand, anticipate, and respond to the issues, expectations, and needs of an individual who has been victimized, and then apply that understanding to providing services so that the service can be tailored to accommodate the needs and vulnerabilities of trauma survivors [13, 16, 19, 20]. Additionally, trauma-informed care ensures that efforts are actively made to reduce the possibility of re-traumatization in clinical or other service settings [13, 16]. A review by Hopper et al. focused on providing trauma-informed care to people who were homeless highlighted four common themes: (1) trauma awareness, (2) emphasis on safety, (3) opportunities to rebuild control, and (4) a strengths-based approach [4, 13].

People who are vulnerably housed are unique amongst those who have PTSD because of the very high rates of exposure to traumatic experiences [1, 2]; the frequent use of substances to self-medicate symptoms [21–23]; high rates of physical and mental comorbidities, including cognitive impairments [5, 24–26]; difficulty in forming caring relationships [17, 27, 28]; and the challenges of engaging with traditional health services often due to poverty and systemic barriers [29, 30]. The National Centre on Family Homelessness outlined several reasons why programs need to be trauma-informed [31], including that trauma can impact how people access services, including viewing people and services as unsafe; recognition that people adapt to trauma to keep themselves safe including abusing substances, becoming aggressive, or withdrawing; and programs and services cannot be "one size fits all". A trauma-informed care approach must work to mitigate the barriers and vulnerabilities faced by this population while providing treatment for PTSD and other conditions.

The high prevalence of trauma in people experiencing homelessness and the integration of trauma-informed care into services as a means of addressing this form the basis for this study. This study is the third in a three-part preparatory phase of a multiphase optimization strategy (MOST) project aimed at developing and testing a treatment program for PTSD and cPTSD in people who are homeless. The first study was a scoping review that aimed to identify interventions to treat PTSD and cPTSD in people experiencing homelessness. This found no randomized controlled trials of trauma-focused therapies and, of the interventions which had been evaluated, none used a trauma-informed approach [32]. The second study was a pilot randomized controlled trial of Narrative Exposure Therapy, a type of trauma-informed psychotherapy, in people experiencing homelessness to assess feasibility and acceptability of the intervention [33]. We found that it was possible to recruit and retain people experiencing homelessness into a randomized controlled trial of a trauma-informed therapy. Once participants had started therapy, they continued to attend, and it was feasible to deliver the therapy in the community (including in shelters and day programs). However, feasibility could have been improved by a better process for engaging potential participants between referral and enrollment as about a third of the referred population were lost at this stage [33]. The current study aimed to describe how we could design a service to engage people experiencing homelessness in a trauma-focused therapy for PTSD or cPTSD as well as explores what trauma-informed care would look like in this setting.

Method

Study design

This qualitative study describes a series of interviews completed with people with lived experience of homelessness employed as peer support workers for organizations that provide services to people who are currently experiencing homelessness. We chose to interview peer support workers due to their unique position bridging lived experience and healthcare provision. This choice was motivated by two key factors. First, peer support workers have personally experienced homelessness, mental disorders and substance use, providing them with valuable firsthand insights. Second, in their current roles, they are often well-positioned to engage and persuade

potential patients to seek help, leveraging their shared experiences to build trust and rapport. Individual interviews were conducted to give people an opportunity to discuss in-depth their personal experiences of receiving care and how trauma could be better accounted for in new services.

Recruitment

Participants were individuals who had their own lived experience of homelessness and were now in a role as a peer support worker. Participants had to be at least 18 years of age or older and speak either English or French. Study eligibility criteria were minimal to ensure broad representation in participants.

We used both purposive and snowball sampling methods to identify potential participants. Individuals known to the research team through relevant community and research collaborations were informed about the study and provided recruitment materials to share with their colleagues. Interested participants then self-referred to the study team. Sample size was guided by both data saturation and information power, in which the number of interviews conducted was informed by the study aims, strong dialogue, and sample specificity [34]. We anticipated that we would complete 15 interviews to reach data saturation and achieve suitable information power.

Participants

A total of 12 participants completed qualitative interviews between November 2022 and August 2024. Interviews averaged 37 min in length and ranged from 29 min to 49 min. Two-thirds of participants (66.67%, 8/12) were women, which is typically representative of peer support workers in this field [35]. Only 12 interviews were completed as it was determined data saturation was reached at this point and further interviews would not yield any new information. To protect participant confidentiality, participants did not provide additional demographic information and will only be identified using their participant ID number.

Data collection

Semi-structured interviews were completed by the principal investigator (SH) using a comprehensive interview guide (Additional File 1) that asked questions about trauma awareness, how to create safe spaces and avoid retraumatization, how to provide opportunities for choice and control, how to be strengths oriented, and how to design and implement a program for people experiencing homelessness that is trauma-informed. Participants were able to complete the interview in either English or French. We used a consensus qualitative research approach as described by Hill et al. (2005) which involves: (1) open-ended semi-structured interviews to allow for the consistent collection of in-depth perspectives and experiences from participants; (2) several judges or coders [NEE, SEM, MJ and PP] throughout the analysis process to encourage multiple perspectives; (3) consensus as the driving force in determining the meaning of the data collected; (4) at least one auditor [SH] to check the work of the coders and minimize the impact of groupthink; and (5) domains, constructs, or core ideas in the data analysis [36]. Interviews were conducted either virtually via videoconferencing platform (Microsoft Teams) or at a location chosen by the participant to increase feelings of safety and trust. Interviews were recorded and transcribed intelligent verbatim by a research team member (MJ) and validated by a second team member (SEM).

Data analysis

We employed an applied interpretivist lens to understand our participants' perspectives on what trauma-informed care is for people experiencing homelessness and how this can be implemented in service delivery, with a recognition that to understand the social world, we must begin with human experience and/or perspectives [37]. Similarly, in taking an applied approach, we highlight that objective and subjective truths are not mutually exclusive and both have a role to play in knowledge development. Specifically, we acknowledge that our own positionality and identities influence what we observe in the field [37, 38]. Of the authors, four identify as cis-gender women (NEE, SEM, MJ, PP), two self-identify as White (NEE, SEM), one identifies as non-White West Asian (Iranian) (MJ), and one as Persian (PP), and one identifies as a cis-gender White man (SH). Several of the authors are multilingual speaking languages including English, French, Persian (Farsi), and Armenian. We acknowledge that this work was conducted on the traditional and unceded territory of Anishinaabe Algonquin Nation and, as settlers, we are committed to implementing the findings of Canada's Truth and Reconciliation Commission and the decolonization of health research.

Thematic analysis was used to identify, analyze and report themes identified in the qualitative data. The analysis was guided by the six steps of thematic analysis outlined by Braun and Clarke [39]. First, during the familiarization phase, all coders [NEE, SEM, MJ, PP] immersed themselves in the interview data by reading each transcript at least twice. Second, the coders completed a round of pilot coding using an open coding technique to identify data extracts that might potentially form the basis of patterns or themes. At the end of this phase, the coders developed a preliminary codebook to guide data analysis; however, they remained open to the possibility that new themes might be identified as analysis progressed. Third, independent focused coding of each transcript was completed, with each transcript

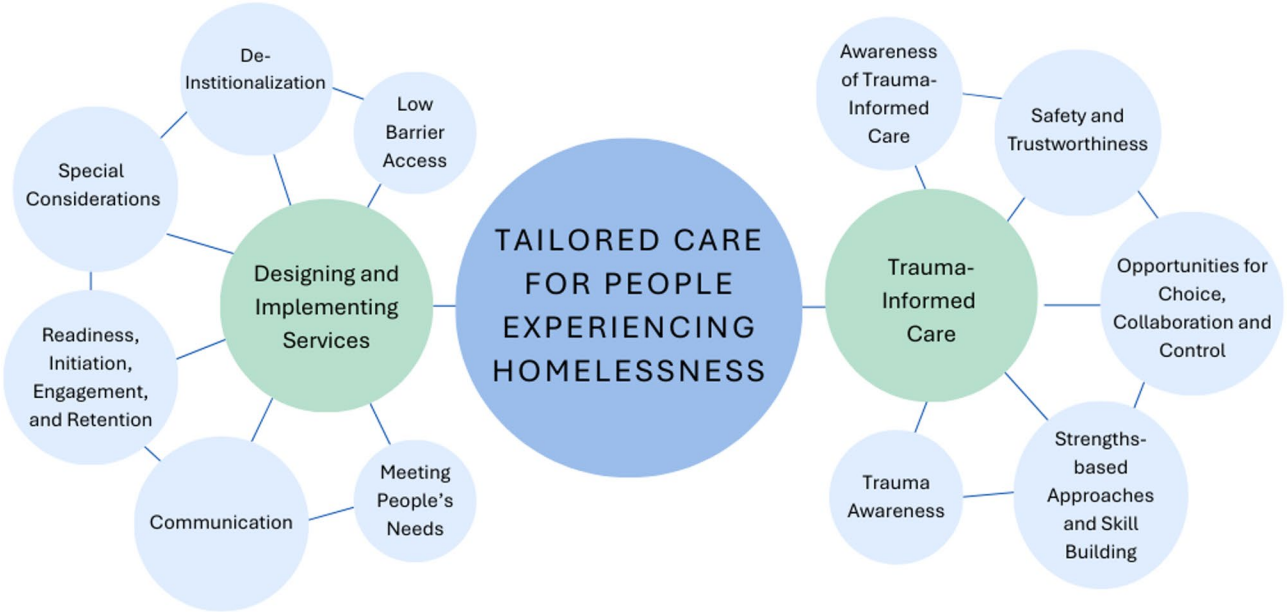

Fig. 1 Thematic map of identified themes on trauma-informed care

coded by two coders. Once initial coding of all transcripts was complete, differences in coding were discussed and reconciled. In cases where coders could not agree, the auditor [SH] was consulted. Fourth, once coding was complete, all coders met to identify overarching themes and sub-themes using a thematic map. During this phase, coders also ensured that themes were both internally homogeneous (i.e., each theme was coherent) and externally heterogeneous (i.e., distinctions between themes were clear and identifiable). Fifth, each theme to be included in the final analysis was then named and defined. Sixth and finally, the final analysis was written based on the prompts identified by Braun and Clarke, including: What does this theme mean? What are its implications? What does the overall story of the different themes reveal about this topic [39]? All data analysis was completed using QSR International's NVivo 13 (NEE, SEM) or NVivo 14 (MJ, PP).

Ethics

Research ethics approval was obtained from the Ottawa Health Sciences Network Research Ethics Board (OHSN-REB ID: 20220197–01 H). The study was conducted in accordance with the Canadian Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans and the Declaration of Helsinki. Informed consent was obtained from all participants prior to study procedures.

Results

A visual representation of the themes identified through the qualitative interviews in this study is outlined in Fig. 1. Themes were grouped into two broad categories: 'Designing and Implementing Services" and "Trauma Informed Care". Included in "Designing and Implementing Services" were themes of "de-institutionalization", "the role of peer support" and "barriers to trauma informed care". Within "Trauma Informed Care" were themes of "safety", "choice and control", "strengths based and validation of experiences" and "what does trauma informed care mean in practice". The main themes are illustrated with descriptive quotes, while all quotes identified are available in Additional file 2.

Designing and implementing services

Participants described in detail the factors they felt should be taken into consideration when designing new trauma-informed services for people experiencing homelessness. This was characterized into 10 sub-themes including communication; low barrier access; meeting people's needs; readiness for treatment; special considerations; continuity of care; post-therapy care; services that provide a sense of purpose; care provider fit; and initiation, engagement and retention. These sub-themes describe a network of factors that challenges the typical "one-size fits all" approach used in many healthcare services to meet the needs of this population.

Communication

Participants highlighted the importance of accessible communication strategies that are adapted to meet both the literacy and health literacy needs of the population. They described strategies such as utilizing trusted community partners and people with lived experience to ensure that language is accessible. Participant 004, for

instance, articulates the importance of accessible language: *"…it's almost like a, like a language barrier. Like if you don't use the right words then, you do not get the outcome… just trying to find like a common ground."* Other key aspects of communication including clarity and transparency in the communication, and using a variety of methods, like phone, email and case workers, to engage with service users:

> *"…encouraging people to seek that support can definitely be really difficult and…you gotta be really honest about what the service is… like "hey, we're, we're trying this new program out, this is exactly what's going to go on in the program, and this is what we are aiming to, you know, have you walk away with" (P001).*

Low barriers to access

How people will be able to use the service was an important consideration for designing services. Participants conceptualized providing accessible low-barrier care as both structural barriers, like location, hours, and appointments, as well as policy barriers.

Adapting the approach to therapy by offering lower commitment engagement can build trust and safety, reducing the impact of traditional structural barriers like set appointments: *"… like a therapy taster, where like you can meet the therapist and like maybe you can talk to them…there could be like drop-in days with the idea being that just somebody could show up and want to talk." (P002).* In order to meet people where they are at, participants also highlighted the importance of removing or adapting policy barriers to ensure that people can continue to access treatment:

> *"…They need to be compliant, they need to accept responsibility for actions… But when we're working with people that are living on the streets, or people with active addictions, they don't fucking remember anything…this expectation that people need to, you know act a certain way to receive that health care, … they're still there and it sucks". (P004).*

In designing services, participants emphasized that it is imperative that patients are able to access care regardless of their circumstances and that there may be unique considerations or adaptations to improve access to the service.

Meeting people's needs

The notion of meeting people's needs ranged from meeting basic needs such as washroom access, food and housing, to more specific practical needs about therapy, such as the length or timing of sessions. Participant 007 notes the importance of housing as a basic need to be addressed for people to effectively engage in treatment:

> *"The Housing First, I think is huge. Because when you're not housed, there's no stability, you know? And you can't begin to work on anything until you have stability." (P007)*

Readiness, initiation, engagement, and retention

Another challenge highlighted in offering therapy services to this population is the readiness, initiation, engagement, and retention in treatment of potential patients. For many patients, starting therapy can be the biggest hurdle. Using peer support workers can help provide emotional support for people beginning therapy without coercing or pressuring clients to engage, which can be understood as "offering an on-ramp" for therapy: *"… giving us [peer support workers] a heads up like 'hey this person's interested'. I, I'm not gonna force anyone to go anywhere but having that, like, encouragement can be really helpful, right?" (P001)*

To support engagement and retention, participants describe creating a safe, reliable, and welcoming space where there is no pressure to participate:

> *"I think it's just having a mainstay… like a space where you're just there whether they come in just eat snacks, or they may choose to talk to you… build it into the fabric as an option always there… And it's, it just has to be it has to be consistent. Consistency is the biggest key because things in their life the only thing that is consistent is the drugs." (P005)*

Participants discussed many other approaches to reduce challenges associated with engagement and retention, including offering incentives such as food, ensuring services provide access to meet basic needs like a shower or a kitchen space, and offering flexibility.

Role of peer support and shared experiences

Incorporating the lived experience of peers may reduce some of the barriers to getting into and engaging with therapy, providing additional comfort to people accessing services. Many participants described the benefit of having a care provider who understood their lived experience: "*I'm a big believer in, in, in peer, peer support… But from a comfort level, from a willingness to open up level… If I know somebody's experienced something similar, I think by default I feel less judged…some inclusion there." (P011)*

Participants emphasized the importance of not feeling judged when they opened up to providers, especially about challenging experiences, and how shared

experiences can reduce feelings of shame and increase comfort in sharing with a provider:

> *"… I found it can be really almost like shameful and debilitating to be working with a practitioner who has no sort of experience in what you're dealing with. It can be so hard to have to disclose information and…you can feel almost judged or ashamed…I always feel more comfortable speaking to people who kind of have an understanding of what you're going through." (P001)*

Special considerations for people experiencing homelessness

Participants also described what we identified as 'special considerations' – or adaptations that may make a tailored therapy service more relevant or accessible to people experiencing homelessness. Participants talked about issues such as cultural competency around Indigenous practices and needs of other racialized people accessing services, accommodating people using substances, and providing opportunities for positive interactions, promoting a sense of purpose and fulfilment for service users.

When asked about ensuring people who are actively using substances can engage in care, Participant 002 highlighted how expectations and interactions need to be re-evaluated: *"…I have to re-remind people…they're high, so they're going to act like somebody who's high…And just like understanding…that this person is doing the best that they can, but that best might not look like the best of somebody else." (P002)*

While food and meeting basic needs was discussed as an important engagement tool, participants also discussed the importance of making space for positive experiences:

> *"I think that one thing…that is always a hit is like country food days…And I've… you know, borne witness to so many of those country food days and it's amazing just the, the level of community…you see all these people coming together and like eating together…So, I think that absolutely, like food is a good incentive, but also like cultural food." (P004)*

This kind of approach provides opportunities to not only focus on trauma and treatment, but to showcase and embrace the cultural diversity within our communities. Further, this approach can foster feelings of inclusion and safety within the service.

Further, they also very clearly outline the importance of acknowledging positionality and lived experience with respect to culture when offering care:

> *"I think that when it, when it comes to trauma, and you know, being trauma informed, we have this idea…of trauma and the things that define us…but oftentimes, and this I see just as a white woman, but I see that we leave out the, the cultural aspect… we don't fully realize … the impact of generational trauma to our Indigenous clients or…the racism that… our Black clients are experiencing every single day, the violence and everything like that…whoever is like when they say that they understand, 'cause it's like, I appreciate the sentiment…the person that I am is not the person that you are there are many different things, there's many intersecting…realities…I try to emphasize, and I even say, like you know, like, I have not lived your life." (P004)*

De-institutionalization

Many participants brought forward the importance of de-institutionalization in implementing trauma informed care. Participants spoke of the need to create both spaces and interactions that feel less clinical, highlighting that many people experiencing homeless have long histories of institutionalization across contexts, including healthcare, criminal justice, and child welfare services. One participant described challenges about the language of 'therapy' and past related harms: *"I think maybe using different language rather than therapy. Because I think once people say even therapy a lot of clients have trauma surrounding therapy, right? Forced therapy and forced counseling or mandated treatment…". (P005)*

Further, de-institutionalizing space was also described repeatedly as one way to support delivery of a trauma-informed service: *"…trying my hardest to de-institutionalize the feel of the place…it can be kind of like re-triggering or re-upsetting to walk into something that feels like a doctor's office, even if it is a doctor's office." (P002)*

The ideas consistently articulated by participants in this theme paint a picture of needing to create a service that is flexible, but reliable, removing as many barriers as safely possible, while clearly communicating what the service offers to patients. The service must also be culturally sensitive and meaningfully prioritize inclusivity in its implementation. Lastly, services should also focus on incorporating positive experiences and provide an environment that supports clients in a holistic manner.

Trauma informed care

The themes in this section were conceptualized using Hopper's framework of trauma-informed care [4]. Participants elaborated on their experience and understanding of the four pillars of Hopper's framework which include trauma awareness, emphasis on safety, opportunities to rebuild control, and strengths-based approach, and what it looks like when these pillars are incorporated into care.

Awareness of trauma-informed care

Several participants discussed being aware of trauma-informed care both in the context of their lived experience and their occupational roles. For instance, when asked how to best design services to take into account people's experiences of trauma, one participant stated: "*Definitely trauma-informed care… but trauma-informed care is not a like black and white treatment, right? It's… almost vague…like the pillars of it are very helpful but obviously it's important to…have a very … well thought out design to implement." (P001)* They highlighted the importance of knowing what being trauma-informed means and how to sustainably put this into practice. Echoing the objectives of this study, one participant clearly highlights their hope that the integration of trauma-informed care into care for this population is meaningful, and not just a passing 'fad': "*… honestly…I feel like it's the newest buzzword…I'm hoping that, you know, it turns out to be more than just a buzzword." (P007)* The remaining themes describe what the components of trauma-informed care mean to people with lived experience, and how healthcare service programs can use these components to implement sustainable trauma-informed services.

Safety and trustworthiness

Safety and trust are key pillars of trauma-informed care approaches. Participants described a breadth of aspects which they felt fostered safety and trust, which we characterized into several sub-themes including emotional safety, no judgement, privacy and confidentiality, physical safety, shared experiences, therapist/care provider fit and trust.

Emotional safety Emotional safety was paramount to how participants conceptualized the role of safety in trauma-informed care. Participants discussed various ways of encouraging emotional safety through compassion, the importance of listening and being present in the moment, diverse representation among staff, adjusted expectations, open, honest, and thoughtful communication, and being mindful of body language.

First, participants highlighted that organizations that embraced diversity and inclusion were often seen as safer spaces. Participants saw this as a potential indication that staff at the organization may be more open-minded about their experiences. This was communicated both through staff representation and welcoming visual cues:

> *"Having like… staff from different sort of walks of life or just more representation. I know for me, growing up, I was always making sure that the places that I was looking at, or was accessing, like were like 'we're LGBTQ + friendly' and like would have even just like the Pride flag. It like made me feel more comfortable than trying to talk to somebody that may not get it or might not have open-minded views." (P002)*

Second, meeting people where they are at and removing expectations of how people will engage with a service was central to how participants understood emotional safety. They further explained that investing in creating emotionally safe spaces in this way could help to demystify psychological therapy, making it more accessible: *"… the idea of…come as you are… I'm not going to judge you over what you're going to tell me… they'll feel comfortable there, and…they're going to be like, Hey, maybe I want to talk to somebody because you're not all scary, terrible people." (P002)*

Third, interviewees emphasized the important role that both verbal and non-verbal communication plays in fostering emotional safety, including active listening, body language, being open, honest, and thoughtful, and avoiding aggressive communication (such as yelling). Building rapport early on was important to create safety with care providers easing into difficult topics: *"our first meeting… I'll just ask the person maybe some stuff about themselves…. to make them feel comfortable…rather than just going straight into it…making them feel comfortable and everything comes from there." (P009)* Encouraging open and authentic communication can create a space where people feel safe to begin discussing difficult topics: *"Making sure that people feel safe, emphasizing that, you know language like, I don't care what words you use to be honest. If you wanna swear, you wanna say any-, I don't care, because I want to see what's underneath that." (P004)*

Lastly, interviewees spoke of how engaging in active listening could help people accessing services find their voice and autonomy, thereby increasing psychological safety:

> *"Well, when a person's been traumatized, like their autonomy has been taken away, their voice has been taken away…It's important to help them find their voice again…it's really important to give them that back like I hear you, I hear what you're saying, like thank you for… being brave enough to share with me…and just create the safe space for them to be themselves again" (P006)*

Physical safety When talking about safety, participants frequently described both emotional and physical safety as important for creating an overall sense of safety when accessing services. Participants suggested several ways to create physical safety including the design of the space: "*For me, it would be one that isn't locked down… one I could…come and go…on my own accord. Might have headphones and music for me to listen to, to self-soothe, somewhere comfortable to sit, lay down if I need to." (P007)*

Participants also highlighted the importance of rules and boundaries, offering private or quiet spaces, and the challenges of creating physical safety in some environments.

One unique consideration in this context is how to address street culture in the context of receiving services. One approach is that street culture, like street names or hierarchy, is left at the door to create a safe environment for people:

> *"So, we don't adhere to street culture at all…and that's why it can be a really safe space right? Because out there, there's the hierarchy… we don't adhere to that at all…there's no outside talk… Everyone needs to respect each other…any problems outside are left at the door." (P001)*

Privacy, confidentiality, and trust Privacy and confidentiality, and trust were regularly described as key to creating safety. Participants describe the use of a client's name, establishing the confidential nature of any discussions and limits to confidentiality, and the challenges of finding somewhere private to have sensitive conversations. Privacy and confidentiality are described as tools used to establish trust with clients, building rapport and feelings of safety. Reinforcing that conversations remain confidential between the provider and the client works to establish trust at the start of each interaction: *"…make that clear…this is…between you and I and I'm very serious about that, you don't need to sign papers…I am here to tell you that…this will not go further than us…I find that traumatized people really need to hear that." (P012)* These concepts work together to create an environment where the client feels that they can share sensitive information without fear of their story being shared with others and where their personal limits are respected in any given interaction.

Opportunities for choice, collaboration and control

Another key component of trauma informed care elaborated on by participants was the idea of creating opportunities for patients to have choice, collaboration, and control in their care. Participants discussed a wide range of subthemes including having autonomy and agency, building relationships, rebuilding control, managing endings, and the role of rules and boundaries.

Importance of choice and allowing people not to choose Several participants talked about having the capacity to make choices and what that looks like in practice. For example, Participant 004 spoke of the tension between the importance of giving patients choices and their ability to make choices in the moment: *"Giving them choices. And then, I'd say also having patience, because not everyone's ready to make choices…like the expectation that people need to, you know, make choices in the moment, they can't always do that." (P004)*

People may also choose not to engage in treatment or may choose to engage in behaviours that are not supporting their wellbeing. Participants also discuss the importance of agency and being engaged in supporting someone's choices in their care: "*So just getting someone's consent and allowing them to make a choice between one thing or another is very different than building a connection with someone and supporting their agency in their overall health." (P003)* These concepts provide additional nuance to our understanding of choice in health settings, emphasizing how to support and respect people in making choices and how to create opportunities for real, informed decision making.

Establishing relationships The importance of establishing relationships as a component of fostering collaboration in a trauma-informed approach was emphasized throughout. Participants talked about offering flexibility and patience when building new relationships, the significance of being heard, and that often informal conversations are key to beginning the therapeutic relationship: *"The people…that help them, they think they hurt them… and that makes a big difference, but you have to explain to them several times…And if you stick out the long haul… they will eventually come to you, you know." (P012)*

Rebuilding control Rebuilding control was highlighted by participants as a key component of this theme, noting that for those who have experienced trauma, control has been repeatedly taken from them. Participants talked about how control can be offered to patients in big and small ways, from something like choosing basic supplies to how and when they engage with care: *"Let the[m] come to you, like I said tell them, you know, I'm here for you, when you're ready, here is number you can call, I'm available or somebody will be available to…talk to you" (P012)*

Participant 004, similarly, expresses how even small acts of agency and autonomy can have a big impact for individuals:

> *"[Drop-in program] [has] like a, a big closet that people can access whenever they want…there's nobody grabbing stuff for them. And that's what I see at [shelter program], right? Like, it's, oh I need something and then…somebody goes and gets it for you… and they come back with something that's like… the wrong size or whatever it is…but you know, giving people the choice to go through the things and like grab what they want? That's great… agency and autonomy." (P004)*

Rules and boundaries Lastly, the importance of rules and boundaries was also discussed in the context of choice, collaboration, and control. Many participants noted the importance of establishing clear rules and boundaries as essential to being trauma-informed. Participant 001 describes the need for rules and boundaries as important, but also that they may also not promote trauma-informed practices:

> *"I feel like I work in a very control-less environment almost… it can be so unsafe…It's a very like almost standardized like "you come down here, you follow the rules"…as much as we love to empower others, like, there's almost like, we're, we're playing part in the re-traumatizing. Because you're coming in and like you've got these authority figures telling you what to do." (P001)*

Strengths-based approaches and skill building

Participants highlighted the benefits, challenges, and aspects of a strengths-based approach as well as the potential damage caused by the rhetoric of being a 'survivor' in the context of trauma as central to this theme.

Frequently clinical assessments focus on what is 'wrong' with an individual, failing to validate lived experiences or to highlight strengths. Participants also describe how challenging it can be for some patients to identify their strengths and how a change in approach in communication can facilitate a strengths-focused conversation:

> *"I find asking strengths when somebody is like in crisis never helps…I used to hate when somebody would be like, "But what can you do really well?" And…all I can think about is what I'm doing bad and…now I'm trying to think of what I do well, and I can't think of anything thing so now I just feel more shitty. Sometimes I like to have that conversation early…being like…what are the things that you do well?" (P002)*

People who have experienced trauma may have difficulty identifying things they would name as strengths. Being able to re-think what a strength might be or how to encourage people think about the things they are good at were listed as important to using a strengths-based approach with people experiencing homelessness.

Participant 007 articulates this idea, discussing how important it can be to re-think what a strength is and how skills might be used in a different way:

> *"I know in active addiction, I had no idea what my strengths were. Not using… I've been learning what my strengths are. And they're just like transferable skills, right? … like I do the budgeting, I do the scheduling, I do all that because those are transferable skills from…my deals with drugs… you know that I was really good at math and it's, it's kind of like applying certain skills from certain things and you know." (P007)*

Similarly, Participant 005 talks about how they try re-think identifying strengths for their clients and providing fulfilment and purpose in their interactions:

> *"When I think often with a lot of our clients they like to be caretakers… like guys who like to save the girls. You know what I mean? Captain save a hoe… And they continuously put themselves in the situation where they help their community…And it's not a mistake, but it's a strength of theirs… it's that wanting to help others right, and I feel like if there were more things that gave our clients opportunity to help others that it would make the community better as a whole." (P005)*

Conversely, participants spoke of how conversations with providers that are intended to focus on strengths can have the opposite effect. Survivor rhetoric was a theme that was brought up consistently by participants and how disempowering the idea of being a 'survivor' was for them. Participants described the importance of the choice of language in providing trauma-informed care such as avoiding describing how "strong" someone must have been, or that they were "a survivor", and the feeling of the trauma being "normalized" or "deserved".

Participant 004 describes their feelings about being "strong" and a "survivor":

> *"I hate that so much… how do, how do people phrase it… like the…bad times made you stronger, it's almost like, like telling people that they deserved to be victims, like it was worth it, you know what I mean?… Who's to say if I didn't have all the shit that happened to me when I was a kid and a teenager that I wouldn't be who I am today, like I'm pretty sure I would be, because my core like beliefs are there, yes they've been shaped by my experiences, but nobody should have had to go through when I went to, nobody deserves to go through what anybody is going through…You survived, and it's like, well sometimes survival is actually awful, like, why didn't I just die…so like the emphasis on…being a survivor…it's so patronizing…it's like they're othering me." (P004)*

This was paralleled by Participant 002:

> *"It's not a nice thing to be told. Like, I used to always hate when people would be like, But you've survived*

so much… you know you're so strong…it just feels really insulting because it's like, Well, I never had the choice…and like our clients, they've never had the choice, they've had to survive." (P002)

Survivor rhetoric was described by some as complex, sharing both positive and negative connotations dependent on the context of the conversation: "*It's incredibly validating to hear that…it depends on…context too…If it's in the context of, Wow, you've survived a lot, sorry, we can't help you please wait six months…then the word resilient becomes a little bit poisonous." (P008)*

Similarly, Participant 006 highlights this dual-sided nature of the use of "survivor" and "resilience":

"I kind of have conflicting thoughts about that because I, I feel like it…highlights the fact that they've been through something, you know? Some people will certainly take that as a compliment or like you're a fighter… I had someone say to me once, like resilience is overrated, I'm tired of being resilient…I just don't want to go through shit anymore, right?" (P006)

Trauma awareness

Being aware of the effects of trauma on an individual is a key underpinning of trauma-informed care. Participants provided a fulsome picture of what being trauma aware meant to them and conceptualized this as being able to recognize trauma and its signs or manifestations, providing compassionate care, gaps in knowledge, avoiding re-traumatization, managing power imbalances between provider and patient, and how to support care providers who also have lived experience of trauma.

One important consideration in providing is care is the multitude of ways that trauma can outwardly present itself and the potential impacts of a lack of trauma-awareness or trauma-informed response: "*My trauma expressed itself in a couple of ways. One was anger. If someone says something that upset me… I would explode…it was just 'hey, Participant 009's behaving badly again.' Yeah. Without understanding why I was behaving badly." (P009)*

Many participants also described the importance of delivering compassionate care as an aspect of being trauma-informed. For example, Participant 006 talks about the need in healthcare to slow down and really listen to patients:

"I feel like the biggest thing that we see a lot in… a lot of society, including healthcare, is rush, which does not work with trauma…everything I know about trauma informed care is just like patience and compassionate active listening. It's hard to… do because…there's a lot of need and not enough staff". (P006)

This was echoed by another participant highlighting how the overburdened medical system presents challenges in providing compassionate care:

"I think the system needs a pretty big overhaul. I think one of the biggest shifts is trying to…put yourself in the shoes of the person…you're treating. What I often find is doctors …you look at symptoms and presentation and you form opinions. And so, it's… the lens of what's wrong with you…instead of maybe what happened to you? …the system was overloaded well before COVID…and I think it's, it's led to a bit more of a cold approach from medical professionals simply because they don't have time, so they're just go, go, go. And unfortunately, the thing that gets lost in that is that interpersonal exchange." (P008)

Participants also discussed the importance of minimizing the risk of re-traumatization of clients and the importance of honest communication. In contrast, Participant 003 talks about how challenging it is to avoid retraumatizing patients when we expect them to continue seeking services in systems or structures that may have traumatized them in the first place:

"That's why I would like to see more light shone onto like those things, like those soft skills and like the mental health training, and like the way that we interact with people and create that kind of social environment is because, like for a lot of people going into a medical system, especially people who've been like marginalized in our society based on their race or like queer or trans people, which is also a big intersection of the population, have entered medical systems and been highly like, physically brutalized, taken advantage of and stuff like that. I think if we shine more light on the social level of it and how we present as an environment…we can work more on taking the edge off and making it more accessible for people to come in." (P003)

Participants also discussed other aspects of having trauma awareness such as how organizations should provide support to care providers who have lived experience to reduce emotional burden and burnout, the role of power dynamics in care interactions, and how frontline workers have to have self-awareness of their own trauma and triggers including how this might impact the care they provide and how to manage this.

Trauma-informed practice barriers Participants also identified that while they view providing trauma-informed care as necessary, there are barriers that may hinder or prevent this approach from being used. Barriers to using a trauma-informed approach that were identified include providing care in environments in which providers have no control over rules or services, the challenges of chaos and time conflicting with patience and empathy, and when leadership does not lead by example. Participant 005 talks about how sometimes factors outside of a providers control often does not provide the space to implement trauma-informed practices:

> *"I feel like working within the [safe consumption site] in a building for which we have no bearings on the rules, makes it very difficult to create a space for trauma informed care, right? Because they're limited as to where they can stay, when they can stay inside, what, what they can wear, where they can get it, when they can eat. It's not, there's no choices for them. You know what I mean? There's, there's one option and this is what it is, and this is the time that it's at. And, and, by doing that, I think we further, for people who have spent a lot of time in incarceration, we're just creating a jail on the outside." (P005)*

For many, services are often provided in chaotic, fast-paced environments where having adequate time to work with clients is limited, as described by Participant 010:

> *"…I always tell my harm reduction workers, if you go to ask somebody how they're doing, you better have the time to be able to listen to them. Nine times out of 10, I'm good. There's going to be that 1% that woke up with no shoes, woke up with all their belongings gone. And you asking them that, you have to be able to give them that time." (P010)*

Validation Participants spoke strongly about the importance of feeling validated in their encounters with care providers. Some of the ways that participants describe feeling validated include acknowledging that they did not deserve the bad things that happened them, not minimizing the experiences people may have had, and that the symptoms they experience are real and have an impact on them. An important component of validation that was brought up repeatedly was shame and guilt. Many participants described the debilitating role that shame and guilt played in engaging with care and its relationship to trauma:

> *"But like for some people…living in such trauma… their sense of self is so low, the shame is so intense that, like this could be the first time they're able to talk to someone about it… And like, that can be huge because…it is the difference between this is something I was able to talk about one time versus I've never been to talk about it with anyone." (P003)*

Ways to talk about client trauma Another important concept was the approach to talking to participants about their trauma. Alternative forms of communication, such as art-based programming, were discussed as ways to open the door to talk about difficult experiences. Specifically, they discussed using arts-based approaches to bridge the gap:

> *"We were doing artist therapy…and like we would just start with the question. And it was very vague… And you can just draw whatever. It could be something traumatic, it could be something not, so like one of the questions is like, how do you view your childhood? Like when you think childhood and yours, what are you thinking? And then just drawing… just kind of like having people process that and then just have a place to put it that's a bit easier than trying to say it also really helps… And like sometimes you can ask the same question later and see what changed.'" (P002).*

Participants used their lived experience to describe how they view trauma-informed care and what practices or approaches providers should use to deliver trauma-informed services. The concepts identified align with Hopper's framework, while expanding on the framework including how to talk about trauma, validation, and barriers to providing trauma-informed care. Participants consistently articulated their support for trauma-informed care.

Discussion

In this study, we examined the perspectives of people who were currently peer support workers with lived experience of trauma and homelessness on what it means to provide trauma-informed care and how to design a trauma-informed therapy for PTSD or cPTSD tailored for people experiencing homelessness. The themes identified in these interviews describe concepts with intricate relationships, often interdependent on each other, which outline the building blocks to create a trauma-informed therapy tailored for people experiencing homelessness.

Trauma-informed care has been shown to be an effective approach in healthcare settings with studies showing improved physical and mental health [40]. The theory of implementing trauma-informed care has also been well documented [41, 42]. However, there are few publications examining the implementation or effectiveness of trauma-informed approaches to care for people

experiencing homelessness [32]. Participants provided recommendations on how to design a trauma-informed therapy including strategies to remove barriers, on the space, and on communication approaches. The importance of incorporating peer support into any trauma-informed service was emphasized noting the role that peers can play in building trust, reducing fear, and facilitating getting people started with therapy. Previous work has reported that the reasons that people experiencing homelessness do not engage in care are complex, consisting of both personal and systemic reasons [43] and embedding peer support may be one approach to improve engagement and foster a trauma-informed approach.

While engagement is a significant challenge, studies have shown that tailored programs have the potential to impact health service use engagement [44]. Our findings echo this, emphasizing the impact that care provider interactions and systemic factors can have on engagement with care, stressing the need for a tailored approach. Importantly, our study emphasizes the value of creating the opportunity for positive experiences, such as offering cultural food days and focusing on strengths, as a way to foster engagement. Adapting the service model from the norm in healthcare by creating a low-barrier space, with no expectations of engagement, and which does not feel clinical were described as ways to tailor a trauma-informed therapy service for this population.

However, implementing these tailored approaches are unlikely to be without limitation. Healthcare systems globally have been faced with ongoing staffing shortages and funding shortfalls, which have continued to worsen, which impact the ability to implement trauma-informed services [45–49]. Our participants also described how these limitations affect care delivery, for example noting that providers having the time to spend with patients and listen is paramount to delivering trauma-informed care which, with the current staffing shortages, is not possible. In their systematic review of implementation of trauma-informed care in health settings, Goldstein et al. found that financing and staff engagement, in particular leadership, were integral aspects of implementation. Mitigating these constraints may be difficult, particularly in low-resource settings, however engaging organizational leadership early to garner support and adequate funding is likely to be key to success. In low-resource settings, prioritizing lower-cost strategies may help to increase feasibility.

People experiencing homelessness often lack a sense of control over basic aspects of their lives, such as a lack of choice over what to eat or being required to present to a shelter by a specific time. As such, prioritizing shared decision-making or providing space for someone not to make a decision will be key to keeping people engaged and satisfied with their care [50, 51]. Interviewees described the importance of providing patients the opportunity to make informed choices and to have agency over their health. Participants described tangible approaches to operationalize patient choice and control in both big and small ways, like choosing clothing or whether or not to engage with care. Safety was conceptualized as something that would need to be created by providers through various actions such as reinforcing privacy and confidentiality of visits, taking time to build rapport and trust, as well as physical aspects of an interaction. This is consistent with other studies which have similarly highlighted considerations such as respect and trust with their care providers, compassionate care, and "being treated like a person" [51, 52]. While safety is a multifaceted principle, created through both active and passive actions by providers, our findings suggest that creating a space where people can "come as they are" and where adequate time is provided to meet people's needs are important underpinnings of being trauma-informed.

Strengths-based approaches have been more commonly used in youth experiencing homelessness [53], with positive results. For adults experiencing homelessness, healthcare interactions seem to focus on "what is wrong", rather than using a strengths-based focus [32]. In our study, participants described the potential difficulties with a strengths-based approach, where low self-esteem and self-worth often stops people from recognizing their strengths. However, they also provided strategies to re-think strengths-based methods, such as having people re-think transferrable skills and using motivational interviewing. Lastly, the impact of being trauma-informed has a direct impact on improving patient outcomes, including improving engagement and wellbeing [40]. Participants in our study similarly spoke about the importance of being able to recognize the signs of trauma and the importance of communication. Of note, was the conversation around "survivor rhetoric" and the importance of language when communicating with people who have experienced trauma. Our participants described not wanting to be referred to as a survivor and cautioning providers to not use language that normalizes the experience of trauma, while acknowledging and validating the patient's experiences.

This has been the first study of its kind examining what is necessary for a service tailored for people experiencing homelessness to be trauma-informed. Our findings provide practical recommendations for designing and implementing a trauma therapy that is trauma-informed tailored for people experiencing homelessness. Understanding the unique considerations for engaging this population in care will help to support feasibility, acceptability, and sustainability of the service developed. Our study also expands on our understanding of the

principles of trauma-informed care by incorporating lived experience perspectives of what each of these principles mean to them and what this looks like in practice. These perspectives can be used by health professionals to consider their current practice and how they can change their approach to be more trauma-informed for their patients. While the focus of our study is on designing a trauma-informed trauma therapy, our findings describe approaches which can be readily applied to new or existing services in health and social services, including inpatient, outpatient and community settings, which may be accessed by people experiencing homelessness.

Strengths and limitations

This study makes important contributions to the field of trauma-informed care and provides valuable insight into what people with lived experience of trauma and homelessness would consider to be a trauma informed approach. It provides the starting point for a novel intervention or therapeutic approach to be co-designed by people with lived and living experience to more effectively deliver programming in this population. While this study focused on designing trauma therapy, many of these results could be easily generalized and implemented in other areas of health service. Further, it is the first study to examine the perspectives of people with lived experience on the principles of trauma-informed care, helping to align the clinical and lived experience views.

However, this study is not without limitations. First, participants were enrolled in the study through self-referral. As such, participants may have a self-selection bias and may not be representative of people currently experiencing homelessness. Second, is that we chose to only include peer support workers. While peer support workers have relevant lived experience, they are a unique group having received additional training and knowledge of healthcare processes. While this positions them to be a valuable source of information, having detailed insight on the topic of this study, it is possible that perspectives of people in different circumstances, for example those currently experiencing homelessness, may diverge from what is presented here. We hope to mitigate this limitation through our future co-design phase which will bring together people with lived and living experience, and other key parties to interpret these findings to design the trauma therapy. Finally, we did not systematically collect any health equity indicators (such as ethnicity, race, or sexual orientation) to reduce burden and to further protect participant confidentiality and it may be that there are differing experiences related to the intersectionality of these characteristics that are not reflected in our results. As such, we cannot draw any further conclusions about these experiences and how it may impact the concept of what it is to be trauma-informed.

Conclusion

These interviews provided critical insight into the lived experience perspective of how to operationalize trauma-informed care for people who are experiencing homelessness. This study is the third component of the preparation phase of a multiphase optimization strategy (MOST). The results from these three studies will provide the foundation for co-designing and testing a novel trauma therapy intervention for people who are experiencing homelessness in the second phase of the MOST approach, a factorial trial. Further, the results from these interviews while specifically focusing on trauma therapy, could be used in other services, both health and social services, for people experiencing homelessness to improve engagement and the service user experience. As the rates of homelessness and related disparities in our communities continue to grow, it is more important than ever to design safe and effective services which take into account the trauma experienced by this population.

Abbreviations

PTSD	Post–traumatic stress disorder
cPTSD	Complex post–traumatic stress disorder
MOST	Multi–phase optimization strategy

Supplementary Information

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Supplementary Material 1.

Supplementary Material 2.

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Authors' contributions

This research was conceptualized by SH, while NEE contributed to the study design. Interviews were conducted by SH. Transcription and validation were completed by SEM and MJ. Coding and analysis were completed by NEE, SEM, MJ, PP. Manuscript was drafted by NEE. Critical review of manuscript was undertaken by all authors. All authors approved the final manuscript.

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Data availability

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

Research ethics approval was obtained from the Ottawa Health Sciences Network Research Ethics Board (OHSN-REB ID: 20220197–01 H. Informed consent was obtained from all participants prior to study procedures.

Consent for publication
Not appliable.

Competing interests
The authors declare no competing interests.

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